| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 50G030 | A. BUILDING _____ B. WING _____ | R 10/01/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CHELSEA GROUP HOME** | **26511 NE VIRGINIA ST, PO BOX 1394 DUVALL, WA 98019** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {W 000} | INITIAL COMMENTS<br><br>This report is a post visit on 10/1/15 to a recertification survey conducted at Chelsea Group Home. All citations were corrected.<br><br>This survey was conducted by:<br>Jim Tarr<br>Shana Privett<br>The Survey Team is from:<br>ICF/IID Survey and Certification Program<br>Residential Care Services Division<br>Aging and Long Term Care Administration<br>Department of Social and Health Services<br>PO Box 45600<br>Olympia, WA 98504-5600<br>Telephone: 360-725-2405<br>Fax: 360- 725-3215 | {W 000} | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.